

Date: _____

(Picture)

Transportation Plan

Participant's Name: _____ Birthdate: _____

Home Address: _____

Home Phone #: _____ Contact: _____

Pick-Up Address: _____

Drop-Off Address: _____

Emergency:

Primary Diagnosis: _____

Special Conditions: _____

Medications: _____

Physician: _____ as of (date): _____
Phone #: _____

Emergency contacts:

Name: _____ Home #: _____ Work #: _____

Name: _____ Home #: _____ Work #: _____

Equipment Transported:

_____ Push Wheelchair

_____ Cane

_____ Guide Dog

_____ Electric Wheelchair

_____ Walker

_____ Other: _____

Wheelchairs:

Does the participant transfer into the seat? Yes _____ No _____

If yes what assistance is needed? _____

Can wheelchair fold-up? Yes _____ No _____

Ways of getting on and off bus:

_____ Lift

_____ Van Stairs

Assistance needed from:

_____ Curb

_____ None (walk on)

_____ Door

Other Information: _____

Signed: _____ Date: _____